MEM-CL-Plan of Care (POC) C3

Purpose: The purpose of this workflow is to provide a step-by-step process for the Health Coach (HC) to develop a Plan of Care that appropriately addresses the Member's individualized needs and barriers related to their health status. The steps include adding the appropriate problem, the associated goal the member wants to accomplish, and the intervention by which the nurse will assist the member in reaching their goal. The nurse will also take into consideration those interventions already captured in the Percolator Call List related to the clinical metrics.

Identification of Roles:

- Health Coach (HC) – Development and on-going collaboration on members individualized treatment plan
- Health Coordinator – Assists Health Coach with scheduling of member appointments and assist with community and support services

Performance Standards:

NA

Path of Business Procedure:

Step 1: Adding a Problem

a. Select Plan of Care from the left Navigation tree
b. Click Add Problem
c. Select a problem from the Problem drop down menu
d. Choose an appropriate category from the Category drop down menu
e. Click Save

Step 2: Adding a Goal

a. Scroll to the right of the Added Problem
    1. Click the Target
    2. Enter the Target Date = the date of next follow-up assessment
b. Choose Goal Class
    1. Your choice will determine the type of interventions displayed when adding interventions
    2. Choose from the drop list

c. Choose a Goal appropriate for the Problem selected
d. Click Save

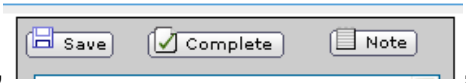
Step 3: Adding an Intervention

a. Scroll to the right of the added problem
b. Click Show - this will expand the problem and goal information
c. Click the Blue! (This is the button to add an Intervention)
d. Select an Intervention from the Intervention drop down menu
    1. The drop down will display a partial sentence until clicked, the entire intervention will display below the drop down
    2. TIP: Click an Intervention then use the "down" cursor key to preview the sentence and scroll through the available interventions quickly
    3. ** Avoid Interventions already addressed on the Percolator Call List **
    4. "Other" can be used to make the Intervention selected more specific to the Member's needs
e. Click Save
f. Select Plan of Care from the left navigation tree; click "Preview Care Plan" to view entire care plan
g. Review the goals with the member
    1. Discuss and agree on a follow up date to review the member's progress relating to the established goals
h. The activity follow up date should be in accordance to touch level by selecting the frequency in the care plan
    1. High= monthly, Medium= only once and adjust dates and Low =semi-annual

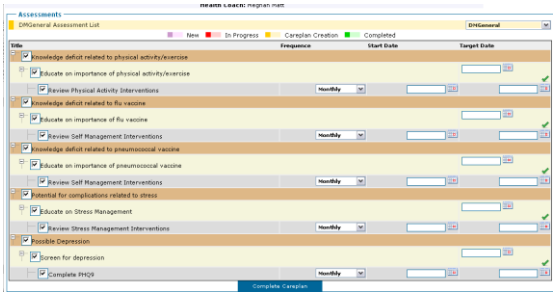
Step 4: Plan of Care

a. The Plan of Care is generated two different ways. A generic plan of care is generated upon completion of most assessments. The health coach is redirected to that site while completing the assessment, as part of that process

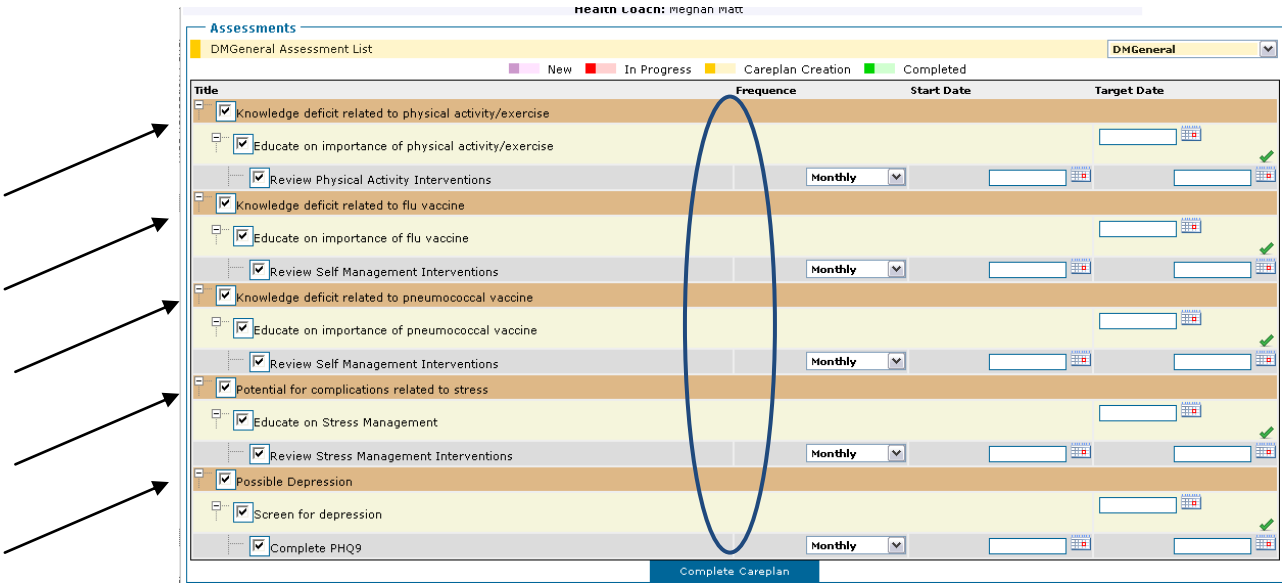
Step 5: Assessment Generated Plan of Care

Once the health coach selects Complete, 

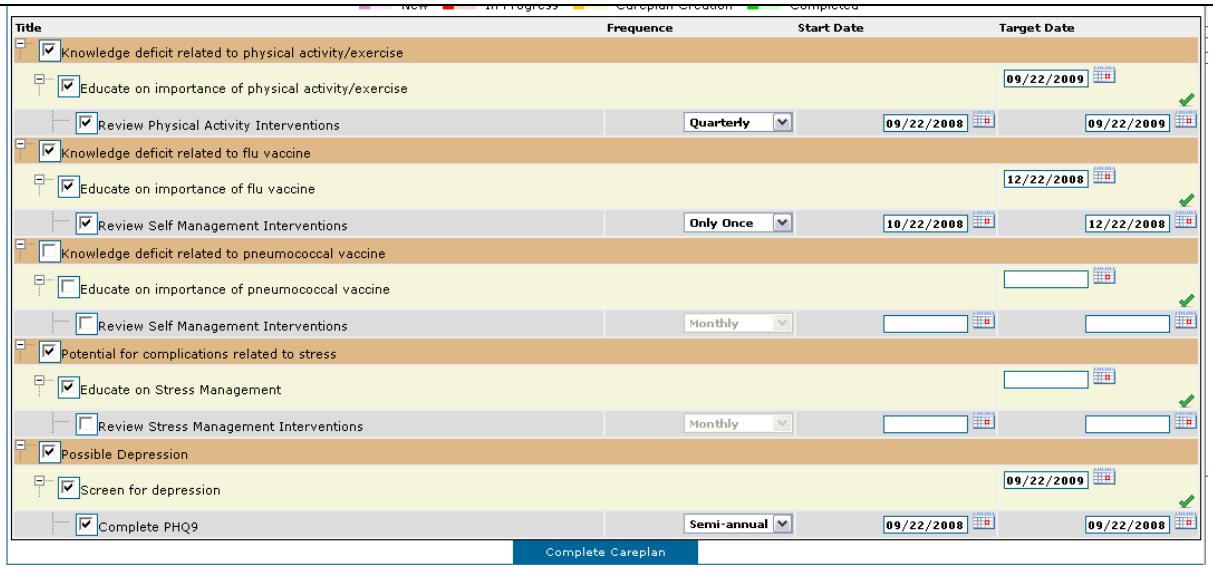
, they will then be redirected to the Plan of Care screen.



a. To modify the care plan, select and deselect by checking the boxes to the left of the Problem Goals and Interventions (PGIs)
    1. If you deselect the problem (brown line), the Goals and Interventions are deselected also. If you deselect the Intervention (grey line), the problem and goal will remain

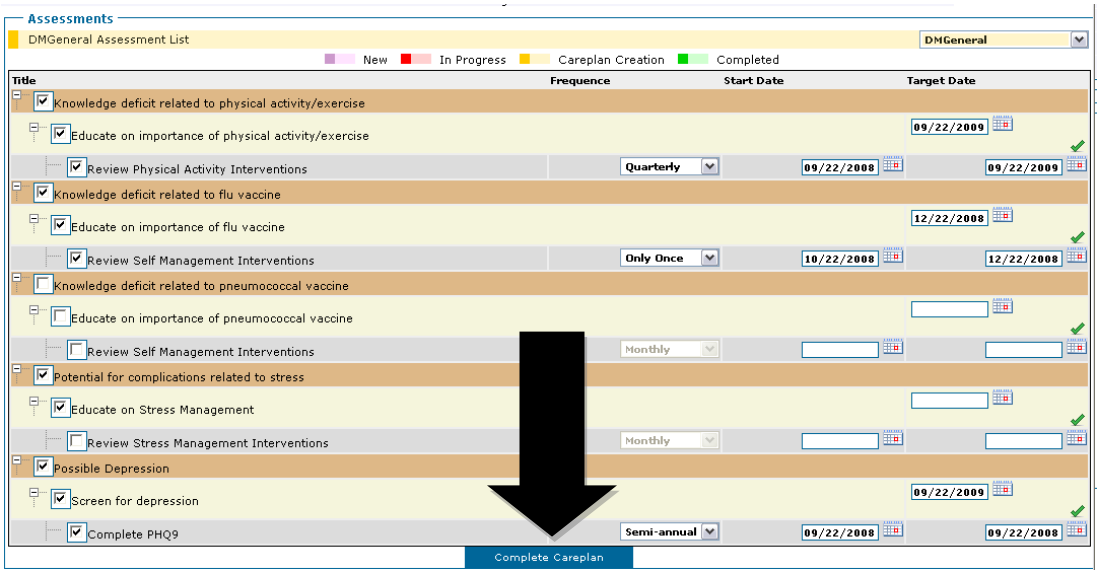


b. Update the frequency of each Intervention by choosing from the drop down
    1. This generates an Activity as a Follow-Up to remind the health coach when to complete the interventions
    2. By selecting Monthly once the Activity has been completed the computer will auto-generate a new Activity one month from the date of completion of the previous Activity
c. Update the target and end dates for each PGI that the HC chooses to keep
    1. The target dates and end dates are the same
    2. This is the date the health coach and the member feel the goal may be accomplished
d. Select the start date, which is the date the health coach will contact the member, and start actively working towards the goal
    1. The health coach can do that by either using the calendar tool or typing in MM/DD/YYYY

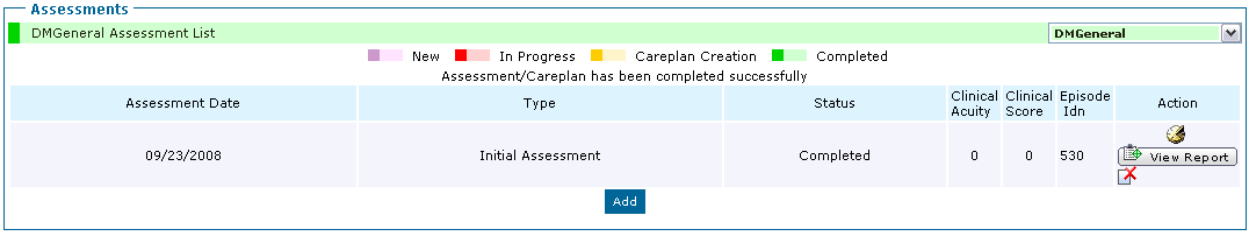


As you can see, here only 3 have been selected for education. At this point, these three will be added to the Care Plan and more PGIs will be added as each assessment is completed

e. Select complete care plan from the bottom of the screen to complete the assessment



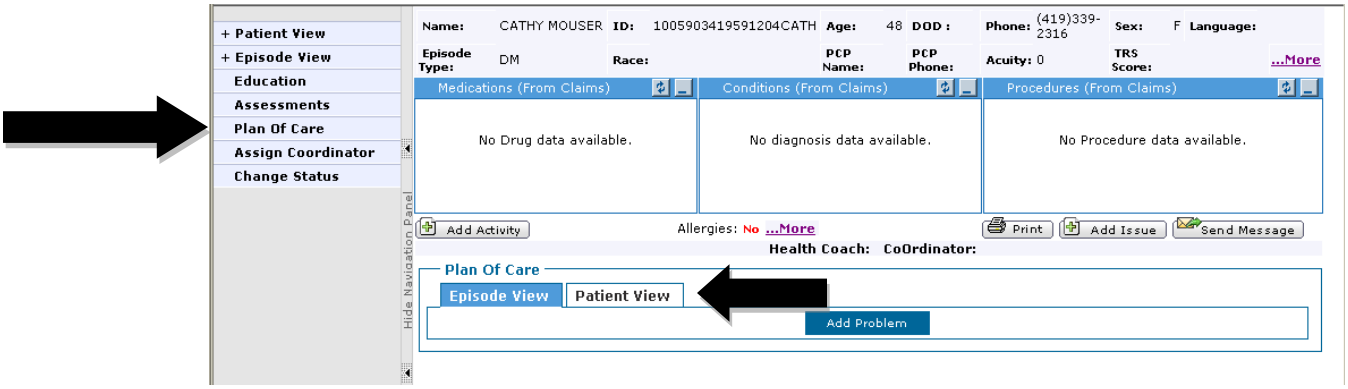
f. This screen will generate, showing the health coach that the assessment has been completed.



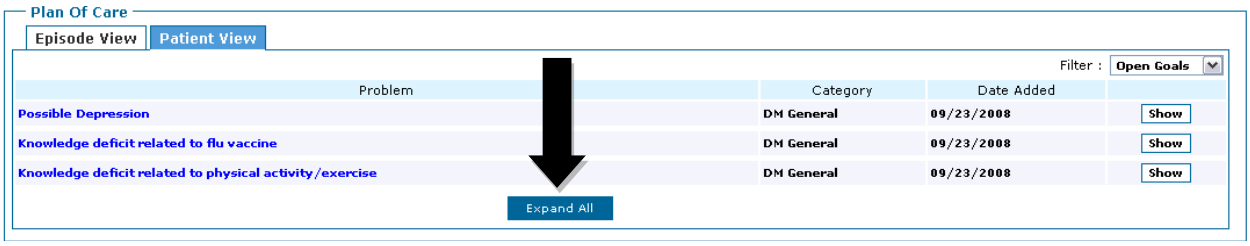
g. Above, you can see that the assessment has been highlighted in green where, on prior screen shots along the top, the health coach can see it was highlighted in yellow (in the Care Plan Creation stage)

Step 6: To change or update information on the Plan of Care:

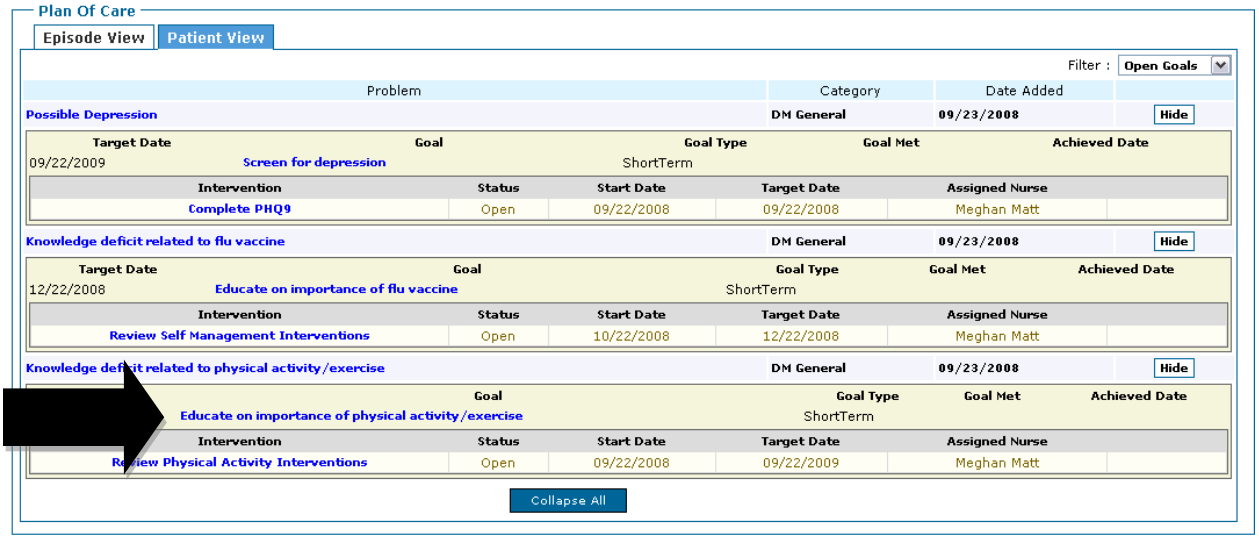
a. Select Plan of Care from the left hand navigation tree
   1. The Plan of Care tab allows the health coach to adjust start dates, call frequency, and end dates for problems, goals and interventions
   2. Within this tab, the health coach may also add problems, goals and interventions



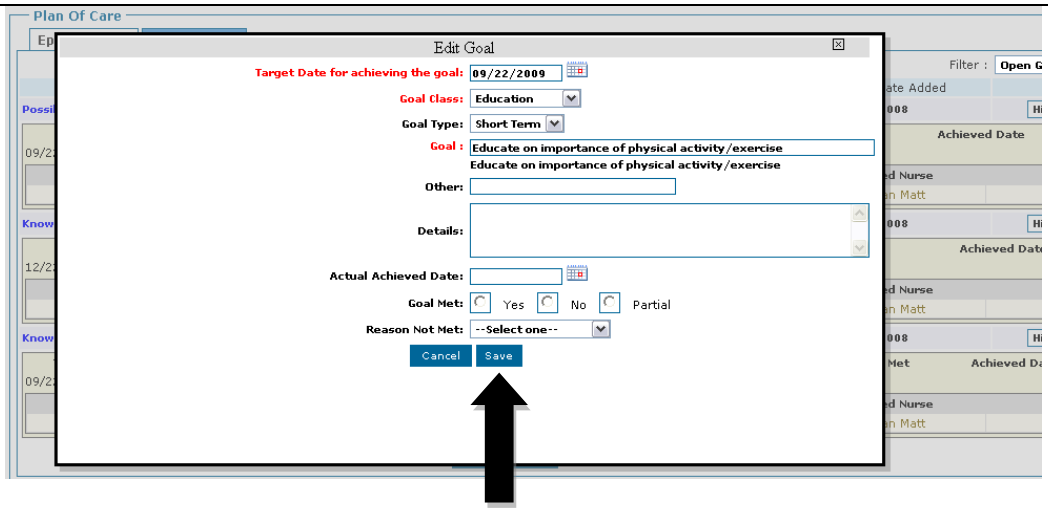
b. Select Patient View in Plan of Care and expand all
   1. The care plan will open up so the health coach may adjust the goal to long term
   2. The health coach may also adjust dates and call frequency in this area as well
   3. Since the health coach will be reassessing the member's disease/condition every 6 months, keep in mind that a long-term goal will be 6 months and a short term goal will be 3 months
   4. This could differ depending on the contract, so please check your department specific workflows



c. Select the goal (Blue link along the goal line of the Plan of Care) to review and update each individual goal after you have created the plan of care
   1. Here the health coach can update the goal type from long to short term, update the dates if information changes, etc.
   2. The health coach will also need to go to this screen to enter the actual achieved date for the goal, if it was met or not, and the variance if needed



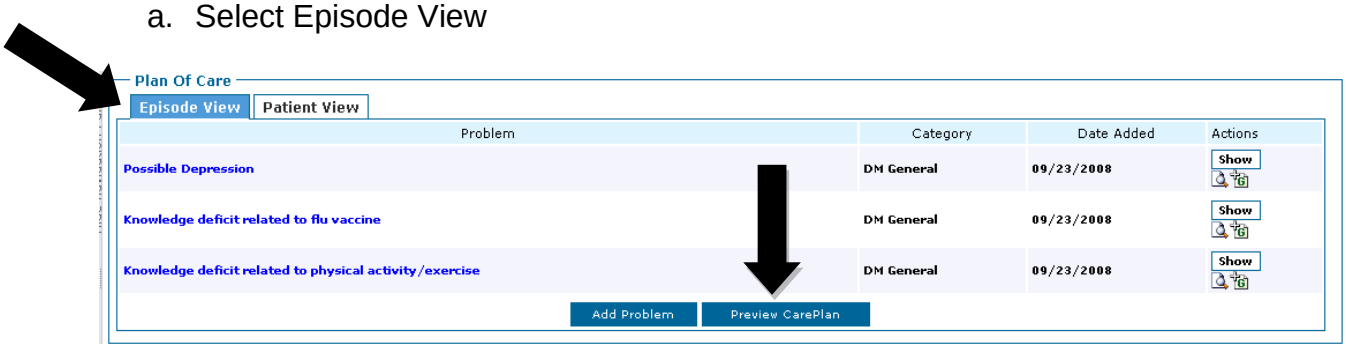
d. Once the information has been changed, select save



Step 7: Episode View of the Care Plan

Another way the Care Plan can be viewed, is found in the Episode View of the Plan of Care

a. Select Episode View



b. Select Preview Care Plan located at the bottom of the screen
   1. Within this screen, it is possible for the health coach to view the last interaction dates and notes for each interaction
   2. In the upper right hand corner is a “print” button, so the health coach could print out the care plan for review or send to the member

Print

Care Plan Preview

Problem	Goals	Interventions	Status	Met	Start Date	Target Date	End Date	CM Assigned	F/U Frequency	Last Interaction Date	Notes
Possible Depression	Screen for depression				09/23/2008	09/22/2009					
		Complete PHQ9	Open		09/22/2008	09/22/2008		Meghan Matt	Semi-annual	-	
Knowledge deficit related to flu vaccine	Educate on importance of flu vaccine				09/23/2008	12/22/2008					
		Review Self Management Interventions	Open		10/22/2008	12/22/2008		Meghan Matt	Only Once	-	
Knowledge deficit related to physical activity/exercise	Educate on importance of physical activity/exercise				09/23/2008	09/22/2009					
		Review Physical Activity Interventions	Open		09/22/2008	09/22/2009		Meghan Matt	Quarterly	-	

3. The health coach will now be able to see the interventions or "activities" for the goals and problems in the open activities/interventions screen

Activities/Interventions

Open Activities/Interventions

Select	Encounter Type	Activity/Intervention	Followup Date	Notes	Added User	Assigned Nurse	Frequ
	Admission	HC will provide the member with the Channing Bete Depression handbook and/or other educational materials	10/27/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	
	Assessment	Phone call to	10/29/2008 12:53 PM	*mbr DM General and Disease Specific	Meghan Matt	Meghan Matt	
	Admission	Complete PHQ9	11/10/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	
	Admission	HC will refer member to the Healthy Weight program	11/12/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	
	Referral	HC will refer the member to a counselor/MD for follow up care	11/20/2008 12:00 AM		Meghan Matt	Meghan Matt	Semi-annua
	Admission	HC will refer the member to a counselor/MD for follow up care	11/20/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	Semi-annua
	Admission	Review Stress Management Interventions	12/08/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	Semi-annua
	Admission	HC provided information/resources for a healthy weight	01/14/2009 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	Quarte
	Admission	Review Nutrition Interventions	01/25/2009 12:00 AM		Meghan Matt	Meghan Matt	Quarte
	Admission	HC will provide information/resources to member/family	04/27/2009 12:00 AM		Meghan Matt	Meghan Matt	Semi-annua
	Admission	Review Physical Activity Interventions	05/11/2009 02:00 PM	Added from careplan	Meghan Matt	Meghan Matt	

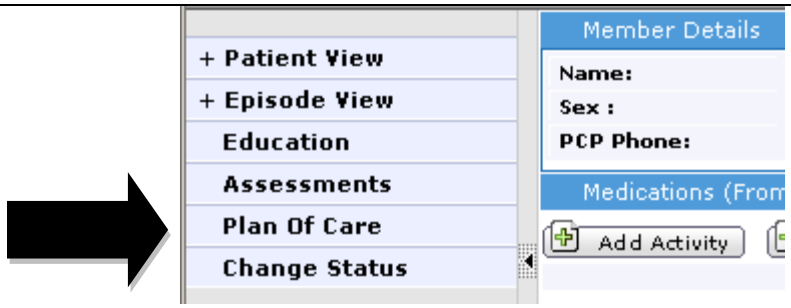
Add New | Modify | Close | Close All

Closed Activities/Interventions

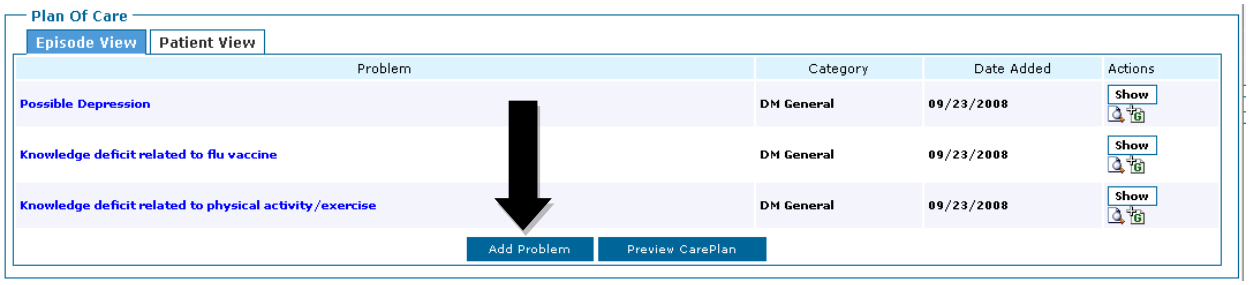
Encounter Type	Activity/Intervention	Followup Date	Notes	Added User	Assigned Nurse	Activity Added
Admission	Review Nutrition Interventions	02/11/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	10/27/20
Admission	HC will provide information/resources to member/family	02/11/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	10/27/20
Enrollment	Phone call from	10/27/2008 10:31	*mbr f/u health fair	Meghan	Meghan Matt	10/27/20

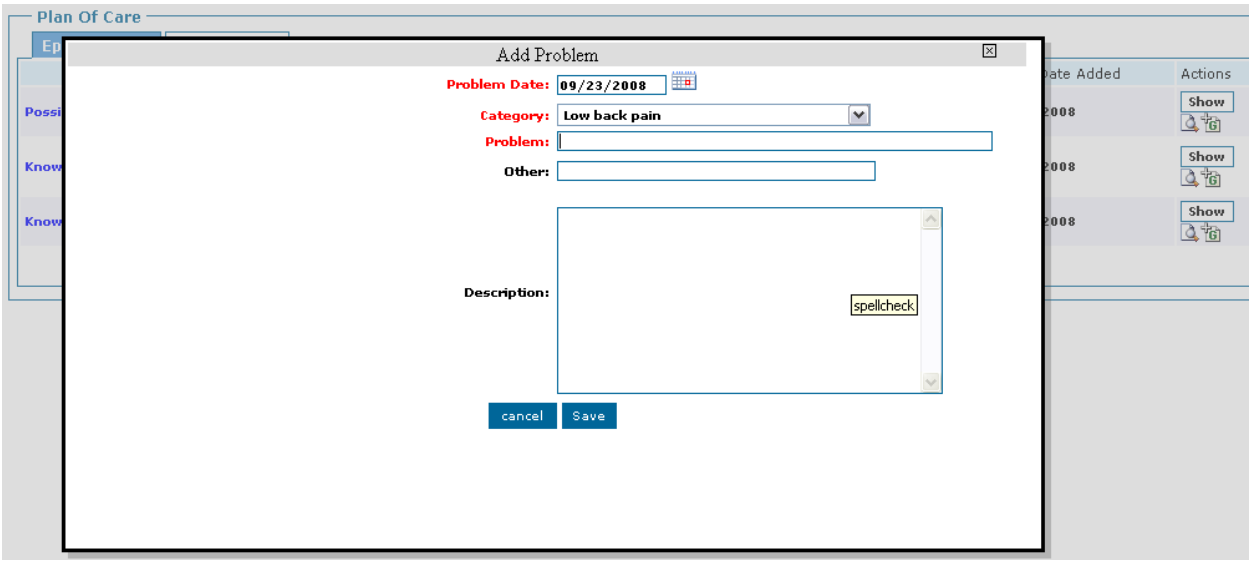
Step 8: Adding PGIs Manually

a. Select Plan of Care from the left hand navigation tree.
   1. The Plan of Care screen will populate



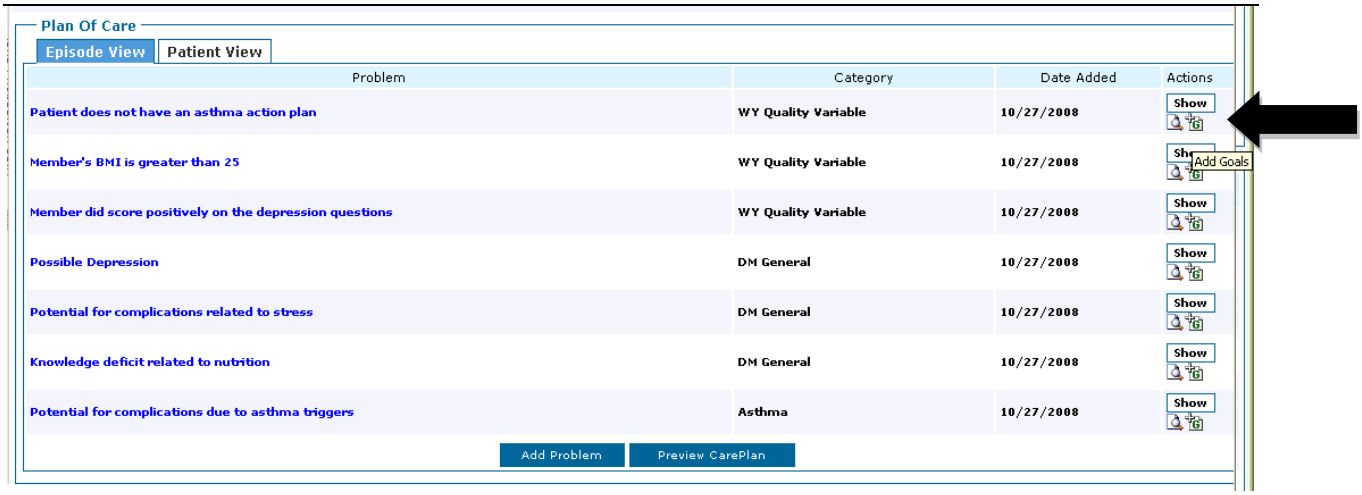
b. To add a problem select Add Problem as seen in the picture below.
   1. After selecting, the Add Problem screen will appear





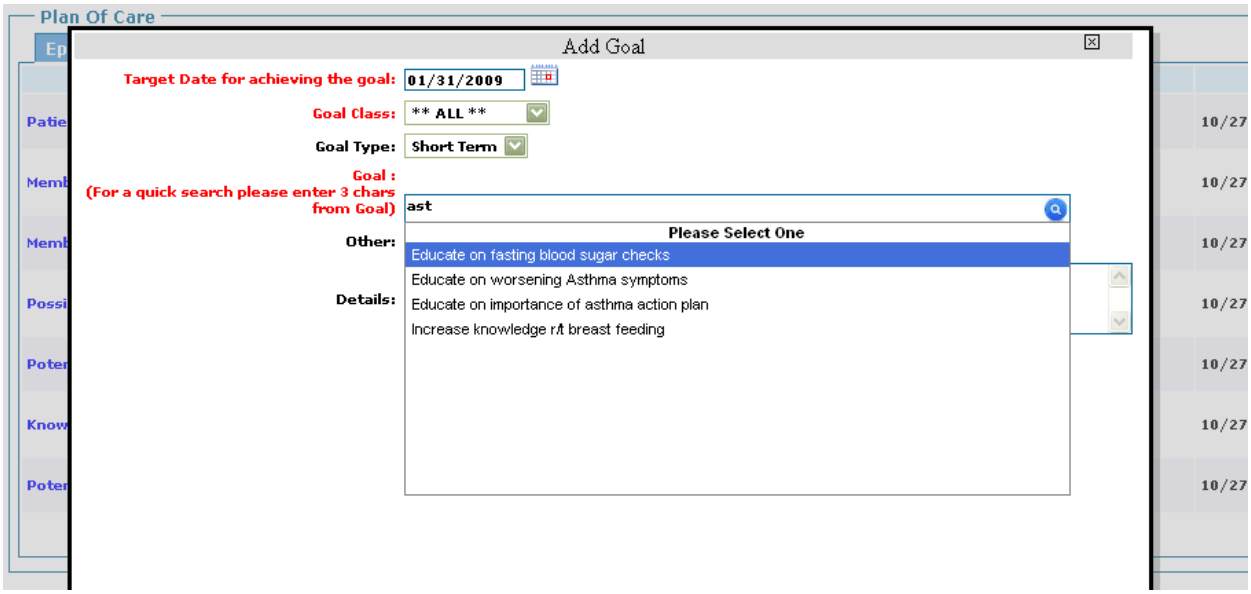
c. The health coach must select a category from the list of options; create a problem, then select save
   1. The problem date automatically defaults to the date that the health coach is adding the problem

d. To add a Goal, select the +G from the right side of the screen, located under the show button



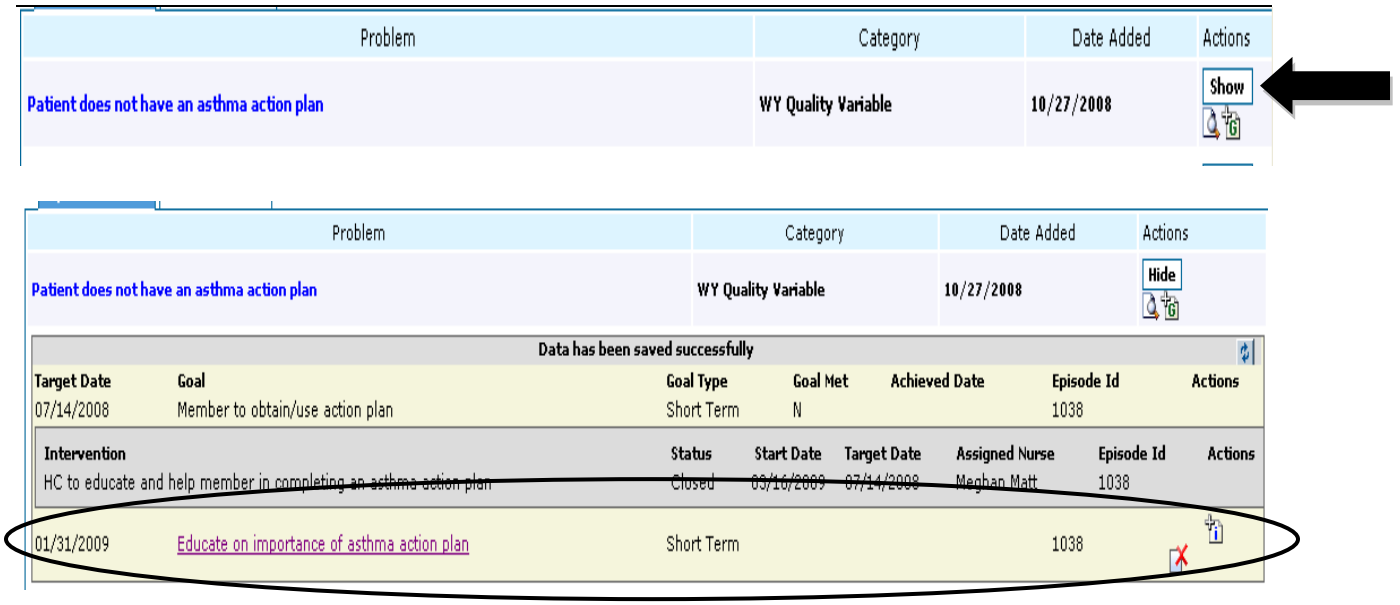
e. Once selected, enter the Target Date, Goal Class, and Goal Type.
   1. Will default to short term, update if it is a long-term goal.

f. Search and find the desired Goal.
   1. To complete the search, only type in the first three characters from the goal.
   2. For example, search using “ast” for Asthma.



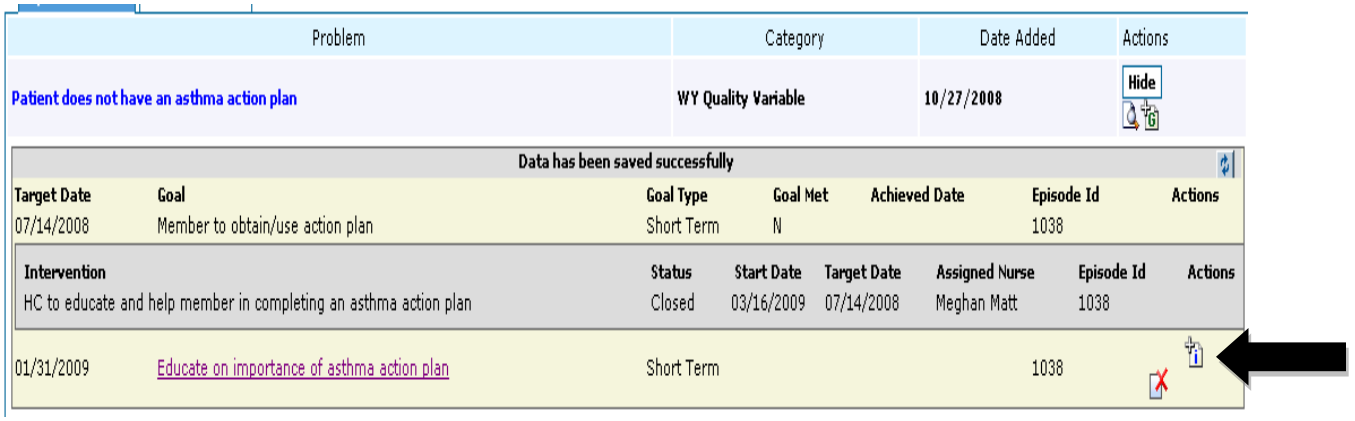
g. Select the goal from the provided options and select save

h. To see the goal listed, select show on the right hand side of the screen, located below the problem where the goal was added
   1. In the screen that populates, the goal will be listed

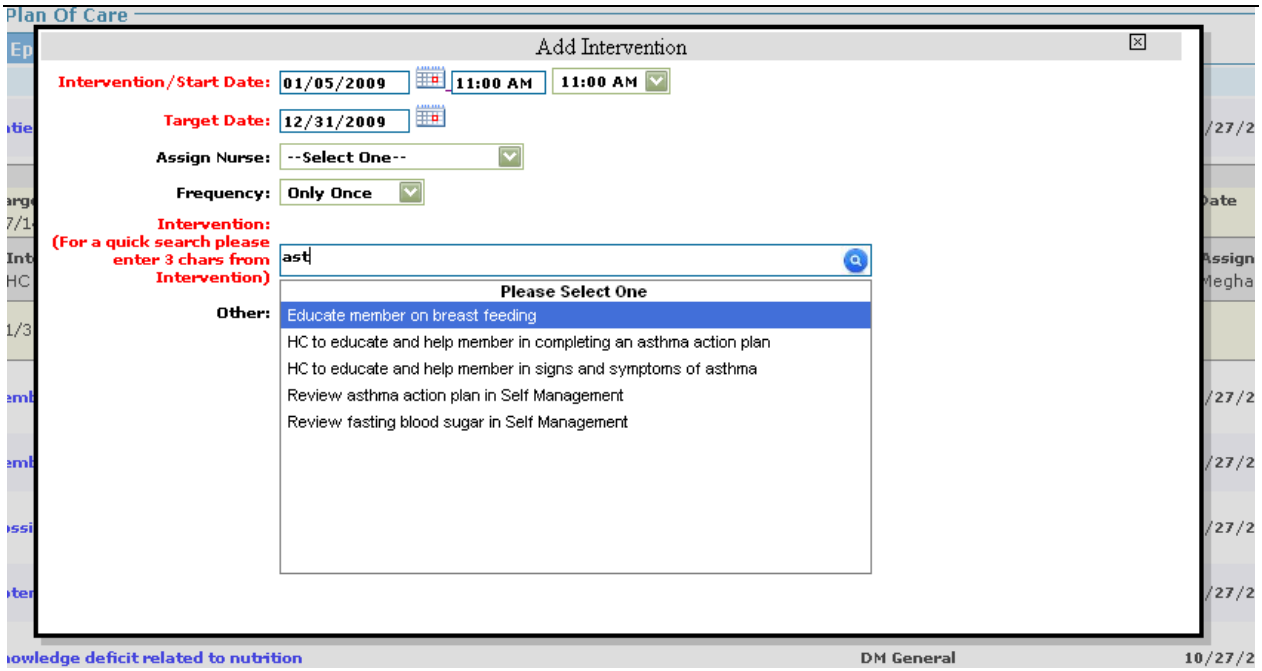


Step 9: Adding an Intervention

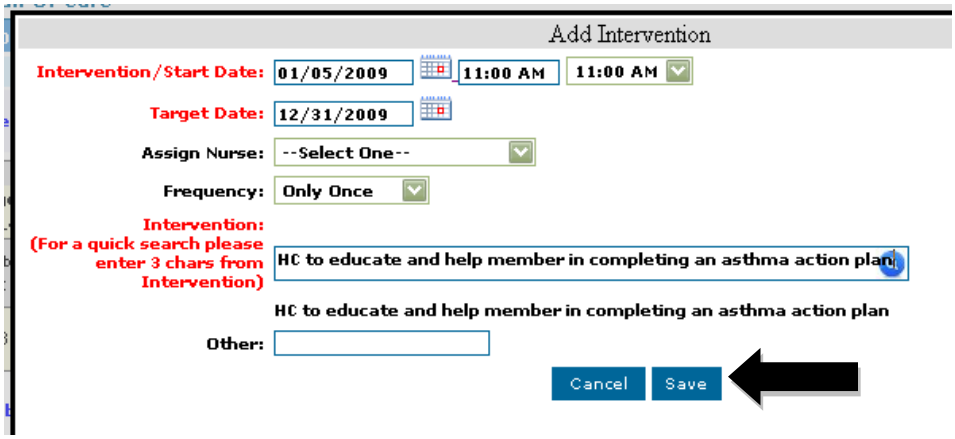
a. Select the +i icon all the way to the right on the line with the goal



b. Enter a Start Date, target date and select an Intervention.
   1. Assign Nurse will update to the current user if not assigned.
   2. Frequency: update to what you want the frequency to be
   3. Type in the first 3 characters of the topic you would like for the Intervention (as done previously with the “ast” for asthma example)

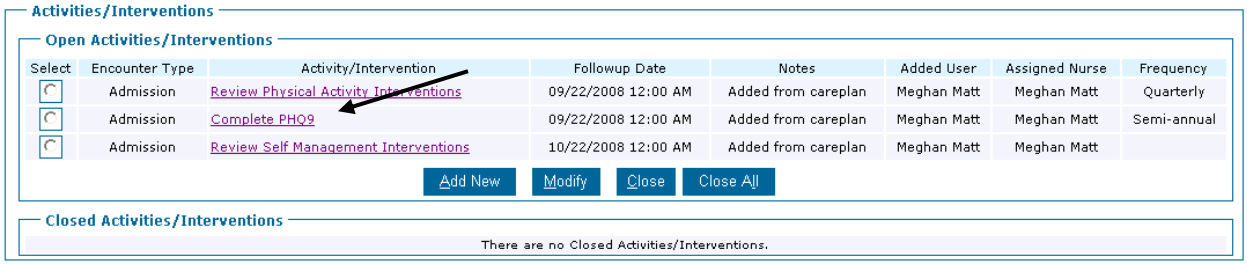


c. Select save and the PGI has been individually added for the member

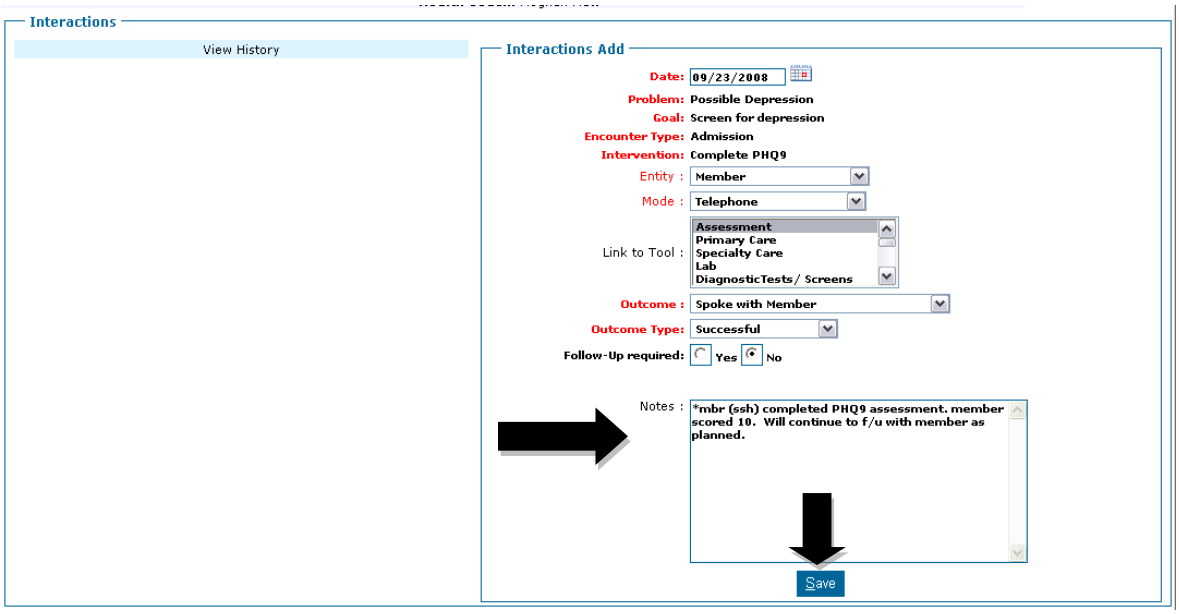


Step 10: Complete a Care Plan Activity/Interaction.

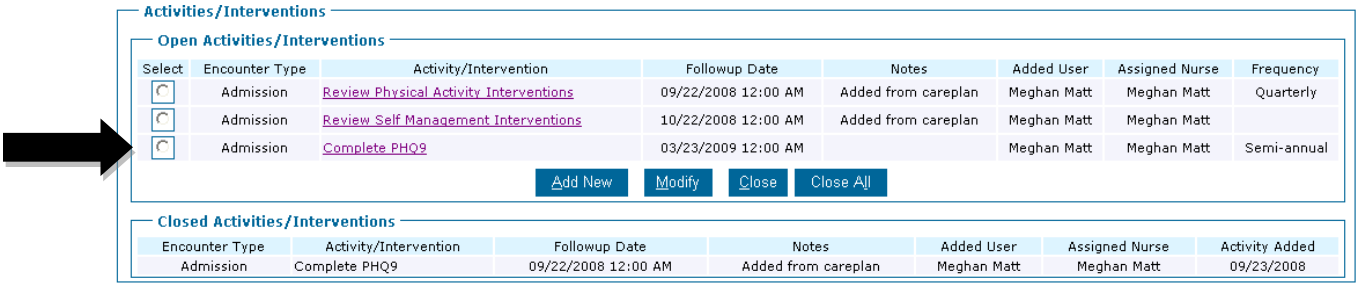
a. Select the activity on the Activities screen in Episode View from the navigation tree (as opposed to within the Plan of Care)
   1. For example: Complete PHQ9.



b. The health coach will fill in the interaction screen with a brief note,
   1. For example: “completed the PHQ9, member scored 10, will follow up as planned”
c. Select save.



d. The intervention/activity that was just completed will be seen under closed activities/interventions



Activities/Interventions

Open Activities/Interventions

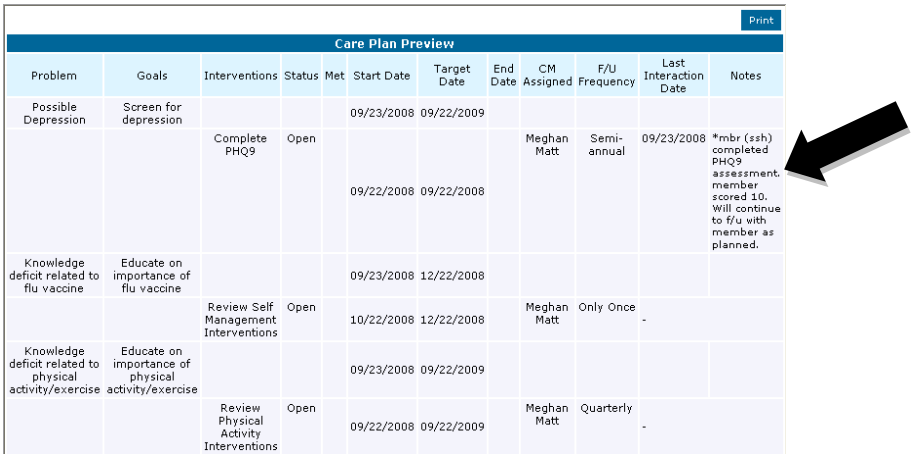
Select	Encounter Type	Activity/Intervention	Followup Date	Notes	Added User	Assigned Nurse	Frequency
	Admission	Review Physical Activity Interventions	09/22/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	Quarterly
	Admission	Review Self Management Interventions	10/22/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	
	Admission	Complete PHQ9	03/23/2009 12:00 AM		Meghan Matt	Meghan Matt	Semi-annual

Add New | Modify | Close | Close All

Closed Activities/Interventions

Encounter Type	Activity/Intervention	Followup Date	Notes	Added User	Assigned Nurse	Activity Added
Admission	Complete PHQ9	09/22/2008 12:00 AM	Added from careplan	Meghan Matt	Meghan Matt	09/23/2008

e. The health coach can go back to the plan of care and see this entry under Preview Care Plan as well.



Print

Care Plan Preview

Problem	Goals	Interventions	Status	Met	Start Date	Target Date	End Date	CM Assigned	F/U Frequency	Last Interaction Date	Notes
Possible Depression	Screen for depression				09/23/2008	09/22/2009					
		Complete PHQ9	Open		09/22/2008	09/22/2008		Meghan Matt	Semi-annual	09/23/2008	*mbr (ssh) completed PHQ9 assessment. member scored 10. Will continue to f/u with member as planned.
Knowledge deficit related to flu vaccine	Educate on importance of flu vaccine				09/23/2008	12/22/2008					
		Review Self Management Interventions	Open		10/22/2008	12/22/2008		Meghan Matt	Only Once	-	
Knowledge deficit related to physical activity/exercise	Educate on importance of physical activity/exercise				09/23/2008	09/22/2009					
		Review Physical Activity Interventions	Open		09/22/2008	09/22/2009		Meghan Matt	Quarterly	-	

Forms/Reports:

Refer to the following operations documents:

Disease Management Assessment Process

My Action Plan- Disease Specific

Clinical Guidelines-Disease Specific

Glossary of Acronyms

RFP References:

RFP MED-6.5.7 Page 197

Interfaces:

C3
Data Warehouse

Attachments:

None